INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Xolair *omalizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Asthma, ICD 10: J45.
☐ Nasal Polyps, ICD 10: J33.
☐ Urticaria, ICD 10: L50.
☐ IgE-mediated Food Allergy, ICD 10: Z91.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Xolair	☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg	Subcutaneous inj.	☐ Every 2 weeks ☐ Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____